

**Semi-Annual Report to the
Joint Legislative Oversight Committee
on Mental Health, Developmental Disabilities and Substance Abuse Services
on**

**Mental Health, Developmental Disabilities and Substance Abuse Services
Statewide System Performance Report
SFY 2006-07: Spring Report**

Session Law 2006-142

House Bill 2077

Section 2.(a)(c)

April 1, 2007

**North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services**

Executive Summary

Legislation in 2006 requires the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to report to the Legislative Oversight Committee (LOC) every six months on progress made in seven statewide performance domains. This second semi-annual report builds on the measures in the October 1, 2006 report.

Highlights

Domain 1: Access to Services – The public system is providing services to slightly over one-third of adults and children with mental illnesses and adults with developmental disabilities. The lack of services to persons with substance abuse problems (less than 10% of those in need) continues to be an area of significant concern. The timeliness of initial services for routine care has risen slightly in the past two calendar years.

Domain 2: Individualized Planning and Supports – Over three-fourths of consumers with developmental disabilities report having input into their service planning, similar to consumers in other states. Family members of children and adolescents with mental health and substance abuse disorders are far more likely to be involved in service planning and delivery than the family members of adults.

Domain 3: Promotion of Best Practices – The new community service array in North Carolina includes best practice models. The availability of those services continues to increase. The Division is working to align use of state-operated facilities in keeping with this increase in community services. In addition the Division is working to improve discharge planning from state-operated facilities to ensure that consumers receive timely follow-up care in their home communities.

Domain 4: Consumer-Friendly Outcomes – Most North Carolina consumers with developmental disabilities report participating in community life and seeing family and friends. Mental health and substance abuse consumers report that services have helped them improve their education, housing, and employment.

Domain 5: Quality Management Systems – Monitoring of provider agencies has increased over the past two years from an average of 188 visits per month to 238 per month. In addition, fewer problems are being identified as needing correction and the timeliness of corrections has improved. Consumer and family advisory committees (CFACs) have been involved in local management entities' (LMEs) quality improvement projects in a variety of ways, from providing input on the topics addressed to having responsibility for the project undertaken.

Domain 6: System Efficiency and Effectiveness – Local management entities (LMEs) continue to exceed requirements for submission of consumer information to the Division. Overall, the LMEs used about two-fifths (40%) of their annual allocations for services in the first half of the fiscal year. The percent of funds used statewide varied from a high of 49% for adult developmental disability services to a low of 10% for child substance abuse services, mirroring the pattern seen in Domain 1.

Domain 7: Prevention and Early Intervention – Over the past 10 years, the Synar Program has reduced tobacco sales to North Carolina's youth from 50% to 10% of attempted purchases. North Carolina provides educational and treatment services to over 26,000 people with DWI convictions annually, with over 5,000 receiving a 10-hour program of early intervention services.

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Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2006-07: Spring Report

Legislative Background

Session Law 2006-142 Section 2.(a)(c) revised the NC General Statute (G.S.) 122C-102(a) to read:

“The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services. The State Plan shall be issued every three years beginning July 1, 2007. It shall identify specific goals to be achieved by the Department, area authorities, and area programs over a three-year period of time and benchmarks for determining whether progress is being made toward those goals. It shall also identify data that will be used to measure progress toward the specified goals....”

In addition, NC G.S. 122C-102(c) was revised to read:

“The State Plan shall also include a mechanism for measuring the State’s progress towards increased performance on the following matters: access to services, consumer friendly outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, and prevention and early intervention. Beginning October 1, 2006, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, on the State’s progress in these performance areas.”

The following is the second in this new series of reports. It builds on the measures reported in the first such report on October 1, 2006. The Division of Mental Health, Developmental Disabilities and Substance Abuse Service is currently working with consultants funded by the General Assembly through Session Law 2006-66 (Senate Bill 1741) to further refine the measures to be included in future reports. The Division is also using this information to set strategic objectives to be achieved in the next three fiscal years. Future semi-annual reports will provide updates on each of the selected strategic objectives as they relate to the domains established by the Legislature.

Measuring Statewide System Performance

The October 2006 report described the initiatives that the Division has undertaken over the past several years to create a foundation for quality management. The Division’s accomplishments in improving its information and quality management systems are necessary foundations for the data included below. While some of the systems have been in place long enough to provide meaningful information in this first year, others are relatively new and will provide information for future reports.

The domains of performance written into legislation reflect the goals of the President’s New Freedom Initiative and national consensus on goals all states should be working toward, specifically to provide support for individuals with disabilities to be able to live productive and personally fulfilling lives in communities of their choice. The Division is in the process of developing a set of standard performance

measures that can be used to evaluate the implementation of system reform efforts and its impact on system performance and consumers' lives. The Division is choosing measures that relate to:

- The goals of the State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services.
- SAMHSA National Outcome Measures (NOMS) (See Appendix A for details).
- Areas of quality recommended in the CMS Quality Framework (See Appendix B for details).

In addition, the Division is aligning measures of statewide performance with local performance indicators, where applicable, so that each LME can evaluate its own progress in relation to other areas of the state.

The performance measures chosen for this second report to the Joint Legislative Oversight Committee are a result of continuing work in this effort. As refinement of measures continues, the Division will set a schedule for updating some standard measures in each semi-annual report and for alternating between a fixed set of annual measures in the Fall and Spring reports.

For each performance area, the following sections include:

- A description of the domain.
- A statement of its relevance to system reform efforts and importance in a high-quality system.
- One or more measures of performance for that domain, each of which includes:
 - A description of the indicator(s) used for the measure.
 - Baseline data or a description of plans to collect the needed information.
 - Division expectations about future trends and plans for addressing problem areas.

Appendices at the end of this report provide information on the data sources for the information included in each domain.

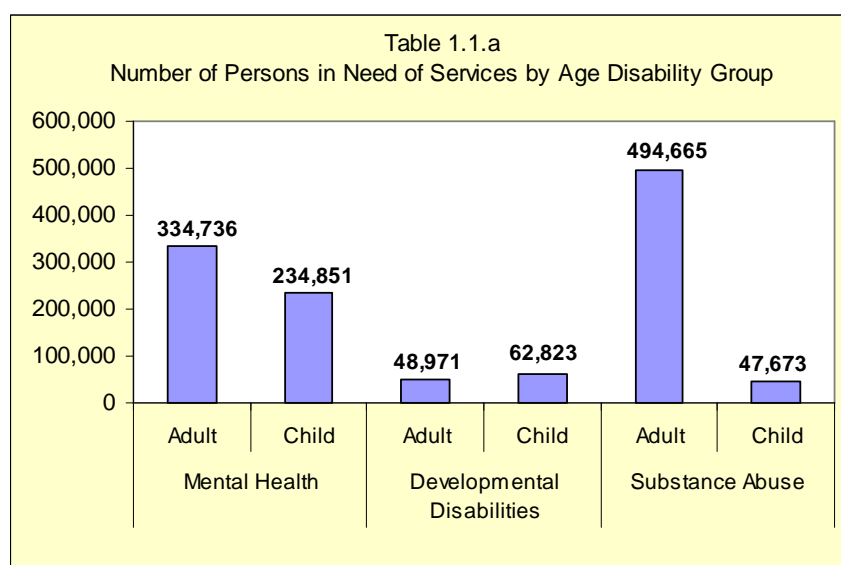
Domain 1: Access to Services

Access to Services refers to the process of entering the service system. This domain measures the system's effectiveness in providing easy and quick access to services for individuals with mental health, developmental disabilities and substance abuse disabilities who request help. Timely access is essential for helping to engage people in treatment long enough to improve or restore personal control over their lives, to prevent crises and to minimize the negative impact of their disabilities on their lives. Both the SAMHSA National Outcome Measures and CMS Quality Framework include measures of consumers' access to services.

Measure 1.1: Persons Receiving Community Services

National research estimates the occurrence of chronic and serious mental health, developmental disabilities and substance abuse problems in the population (*prevalence*). (See Appendix C for sources.) Based on the most recent estimates,² every year:

- Approximately 12% of children and adolescents (ages 9-17) and 5.4% of adults (ages 18 and older) face serious mental health (MH) problems. Although no estimates for children under age 9 have been established, studies include estimates ranging from 11% to 18%.³
- Approximately 7.2% of adolescents (ages 12-17), 17.3% of young adults (age 18 to 25), and 6.3% of older adults (age 26 and above) face serious substance abuse (SA) problems.
- Approximately 3.4% of children and adolescents (age 0-17) and 0.8% of adults (age 18 and above) have developmental disabilities (DD).



When these estimates are applied to North Carolina's populations,⁴ this translates into almost 335,000 of North Carolina's adults needing mental health (MH) services and almost 495,000 needing substance

² These estimates have been updated to reflect the most recent information provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and research on developmental disabilities that have been published since the October 2006 report and the *Long Range Plan For Meeting Mental Health, Developmental Disabilities, and Substance Abuse Service Needs for the State of North Carolina* (C. Thompson and A. Broskowski, December 2006). See the Appendix C for source information.

³ The Division applies the estimates established for ages 9-17 to all children ages 0-17 to estimate the numbers of North Carolina children and adolescents in need of mental health services. See Appendix C for more information.

⁴ The numbers presented here include all persons in North Carolina estimated to need mh/dd/sa services, including those who may be served by private agencies or other public systems. The Division of MH/DD/SAS is responsible for serving persons ages 3 and above. The Division of Public Health is responsible for all services to children from birth through age 2. Local educational systems are responsible for educational services to children with developmental disabilities through age 21.

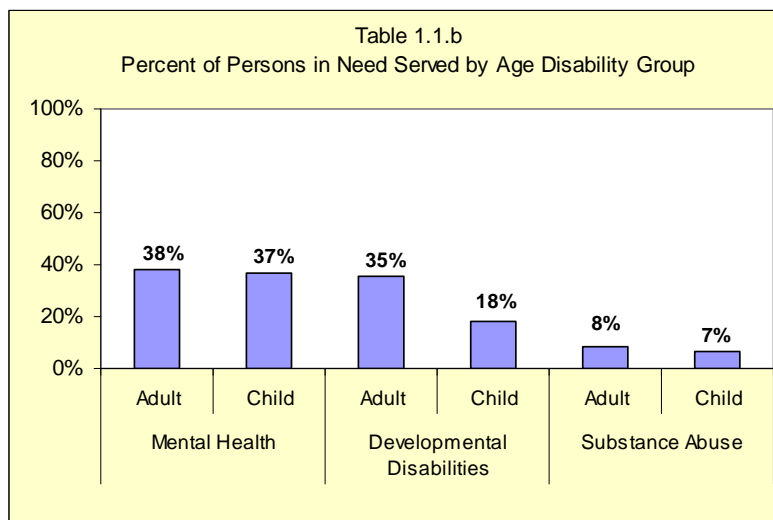
abuse (SA) services each year. Approximately 49,000 adults need services and supports for a developmental disability (DD).

Almost 118,000 of the state's children and adolescents ages 9-17 experience a serious emotional disturbance (SED) in any given year. Assuming the 12% prevalence rate for older youth (ages 9-17) also applies to children under age 9, an additional 117,000 children ages 0 to 8 experience MH problems each year that, if not addressed, can lead to a MH disorder. Almost 63,000 children and adolescents (ages 0-17) in North Carolina have DD and almost 48,000 adolescents (ages 12-17) experience a diagnosable SA disorder.

The Division is committed to serving individuals with mental health, developmental disabilities, and substance abuse needs in their communities rather than in institutional settings. Tracking the number of persons in need who receive community-based services (*treated prevalence*) through the public mh/dd/sas system provides a barometer of progress on that goal.

Not all persons in need of MH/DD/SA services – especially those with MH and/or SA issues – will seek help from the public system. Those who have other resources, such as private insurance, will contact private providers for care. However, many will not seek help at all, due to a lack of knowledge of what services are available or how those services can help. In addition, cultural stigmas against admitting problems and distrust of governmental programs keep others from seeking help. For these reasons it is difficult to determine how many of those in need the state should expect to serve. **The Division is focused on improving services to individuals currently served in the public system, while increasing access to others who need services.**

Table 1.1.b presents the percent of persons in need who received publicly-funded community-based services during the most recent 365-day period for which claims data are available (October 1, 2005 – September 30, 2006).⁵ This percentage provides information with which to establish reasonable targets and evaluate the need for future changes to fiscal or programmatic policies.



⁵ The number of persons in need of services (the denominator) includes North Carolinians that the state's MH/DD/SA service system is responsible for serving (ages 3 and over for MH and DD, ages 12 and over for SA).

Overall, the state is addressing one-fourth (24.5%) of the need across all disabilities.⁶ The state's public system serves only 8% of adults with SA disorders compared to approximately 38% of adults with MH disorders and 35% of adults with DD. This is, in part, a reflection of the greater access to Medicaid services that individuals with MH and DD have in comparison to individuals with SA disorders.

The state serves 37% of children and adolescents (ages 3-17) who need MH services and 18% of children and adolescents (ages 3-17) needing DD services. Approximately 7% of adolescents (ages 12-17) in need of SA services receive them through the state's MH/DD/SA service system.

The Division continues to work with LMEs and providers to design and implement new strategies to better identify and engage individuals in need of SA services.

Measure 1.2: Timeliness of Initial Service

Timeliness of Initial Service is a nationally accepted measure⁷ that refers to the time between an individual's call to an LME or provider to request service and their first face-to-face service. A system that responds quickly to a request for help can prevent a crisis that results in more trauma to the individual and more costly care for the system. Responding when an individual is ready to seek help also supports his or her efforts to enter and remain in services long enough to have a positive outcome.

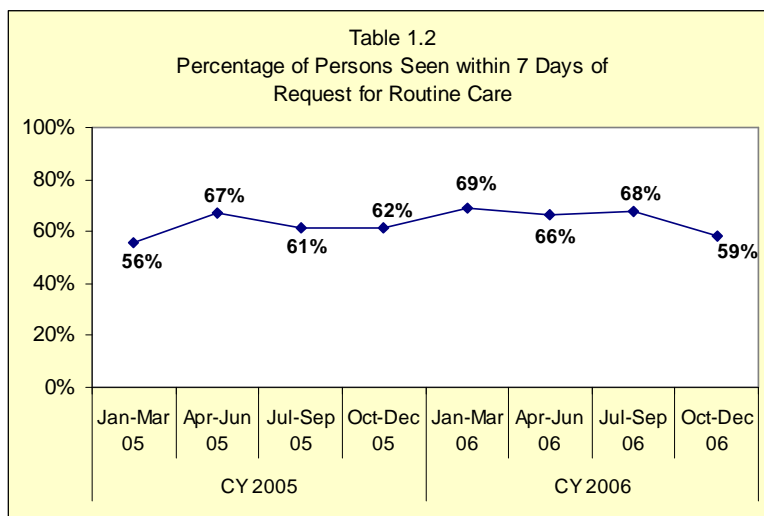


Table 1.2 shows that the percentage of all consumers seeking routine (non-urgent) care who were actually seen by a provider within seven days of requesting services has increased only slightly in the past two fiscal years. After reaching a high of 69% in the third quarter of SFY 2005-06, the percentage has dropped back to 59% as of the second quarter of SFY 2006-07. Difficulty in improving on this measure of access is likely a reflection of the current need for more community-based providers. However, the percent of those who are seen within two hours in emergency situations and within 48 hours in urgent situations continues to be over 99% and 79% respectively (not shown).

⁶ See Appendix C for details.

⁷ Health Plan Employer Data and Information Set (HEDIS©) measures.

The Division continues to work with LMEs to reach the established goal of having 85% of consumers receive their first services within 7 days of their request. The Division's statewide Consumer Screening/Triage/Referral Interview and Registration Form, which was implemented in November 2006, is helping to standardize practices across the state and raise awareness about this important component of the system. **The Division expects performance in this area to improve as the provider system becomes stabilized.**

Domain 2: Individualized Planning and Supports

Individualized Planning and Supports refers to the practice of tailoring services to fit the needs of the individual rather than simply providing a standard service package. It addresses an individual's and/or family's involvement in planning for the delivery of appropriate services. Services that focus on what's important to the individual, and their family when appropriate, are more likely to engage them in service and encourage them to take charge of their lives. Services that address what is important for them produce good life outcomes more efficiently and effectively.

The CMS Quality Framework encourages measuring the extent to which consumers are involved in developing their service plans, have a choice among providers and receive assistance in obtaining and moving between services when necessary.

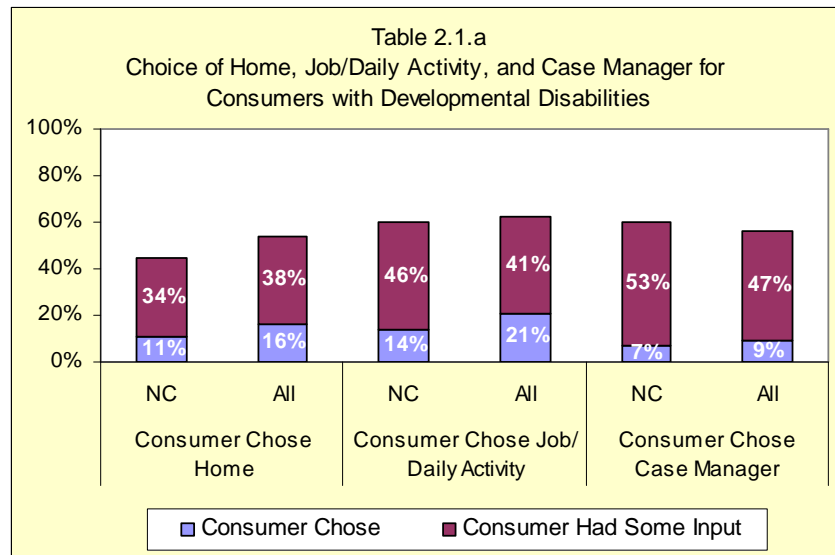
Measure 2.1: Consumer Choice

Offering choices is the initial step in honoring the individualized needs of persons with disabilities. The ability of a consumer to exercise a meaningful choice of providers depends first and foremost on having a sufficient number of qualified providers to serve those requesting help. The identification of qualified providers began in earnest with the implementation of new service definitions on March 20, 2006. As of February 2007, the LMEs had almost 2,500 active agencies providing community-based services across the state.⁸

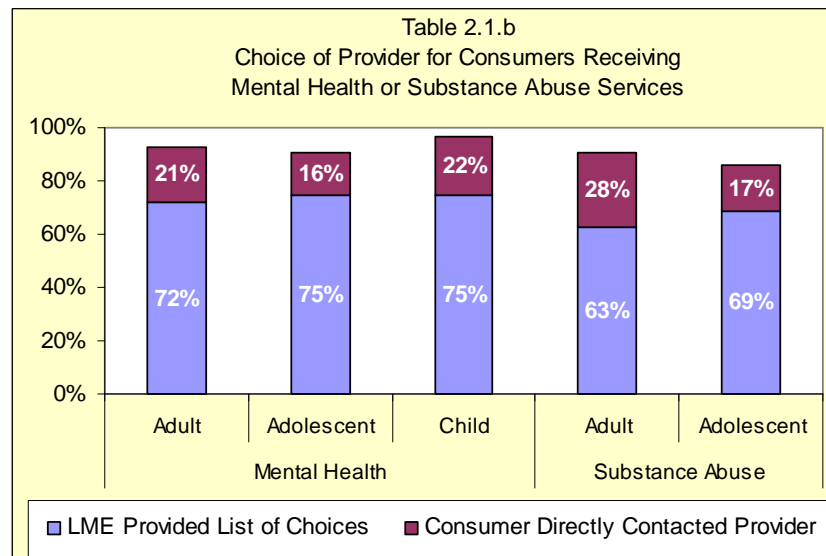
Finding the right provider and situation can mean the difference between willing engagement in services or discontinuation of services before recovery or stability can be achieved. With sufficient provider capacity, consumers have an opportunity to select services from agencies that can meet their individual scheduling and transportation requirements, address their individual needs effectively and encourage them in a way that feels personally comfortable and supportive. The tables on the following pages address the extent to which individuals report having a choice in where and by whom they are served.

Consumers with Developmental Disabilities (Table 2.1.a): In SFY 2005-06 interviews, sixty percent of consumers with DD reported having at least some input in choosing their case manager and their job or daily activities, much like consumers from other states participating in the project. Almost half of consumers (45%) reported having input into where they lived, compared to 54% in all participating states combined. (See Appendix C for more information on this survey.)

⁸ See Appendix C for details.



Consumers with Mental Health and Substance Abuse Disabilities (Table 2.1.b): About three-fourths of mental health consumers and two-thirds of substance abuse consumers reporting outcomes data in SFY 2005-06 said that the LME gave them a list of providers from which to choose services. Most of the rest chose to contact a provider directly before contacting the LME. (See Appendix C for information on NC-TOPPS).



These results provide encouragement that system reform is offering opportunities for consumers to have input into their services. **The Division expects the current positive trends to continue on this measure.**

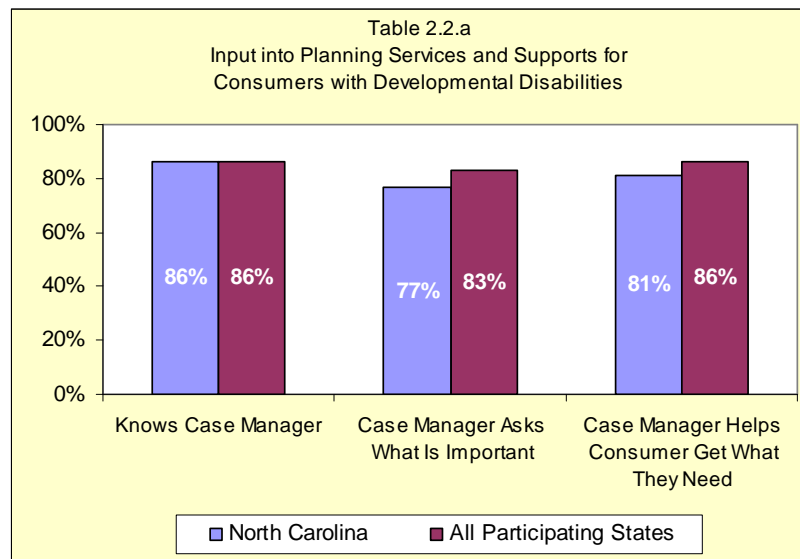
Measure 2.2: Person-Centered Planning

A Person-Centered Plan (PCP) is the basis for individualized planning and service provision. It allows consumers and family members to guide decisions on what services are appropriate to meet their needs and goals and tracks progress toward those goals. The Division requires a PCP for each person who

receives enhanced benefit services,⁹ and has implemented a standardized format and conducted training to ensure statewide adoption of this practice. The Division is currently working with a consultant to refine mechanisms to measure the implementation and quality of this important foundation of a consumer-centered system.

As the following tables show, a large majority of consumers are involved in the service planning and delivery process.

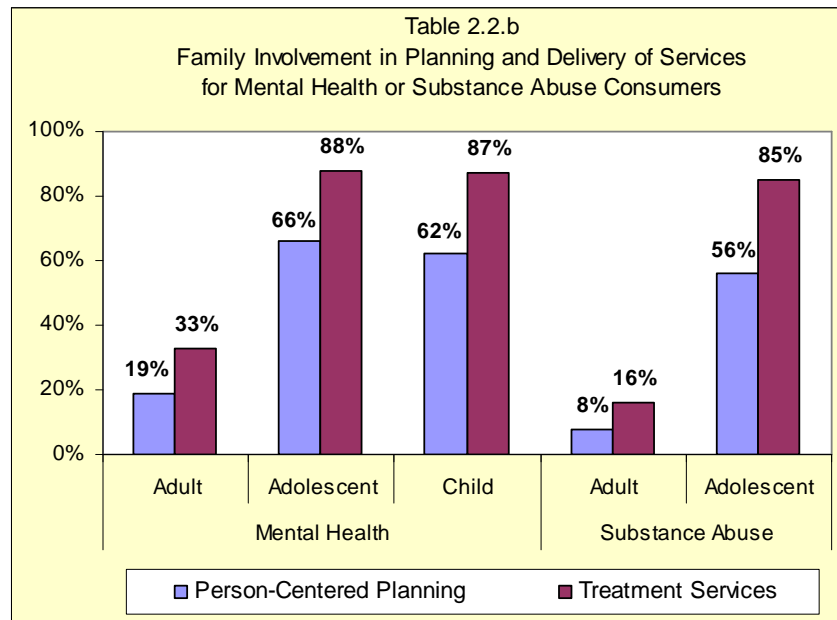
Consumers with Developmental Disabilities: In three key areas related to service planning, about four-fifths of consumers with developmental disabilities interviewed in SFY 2005-06 reported having input into their services and assistance in getting what they need. North Carolina consumers responded much like consumers in other states using this survey.



Consumers with Mental Health and Substance Abuse Disabilities: As reported in October 2006, over three-fourths of mental health and substance abuse consumers in a SFY 2005-06 survey reported choosing their treatment goals. In addition, as shown in Table 2.2.b, over half of the families of children and adolescents are involved in service planning and over four-fifths are involved in service delivery. In contrast, relatively few family members of adult consumers report being involved in planning or service delivery processes. Almost two-thirds (63%) of the families of adult MH consumers and four-fifths of the families of adult SA consumers had no involvement at all in either the planning or delivery of services, compared to about 10% of the families of child and adolescent MH and SA consumers.¹⁰

⁹ “The enhanced benefit service definition package is for persons with complicated service needs.” *State MH/DD/SAS Plan 2005*, p. 58.

¹⁰ Only 8% of the families of adolescent MH consumers, 7% of families of child MH consumers, and 11% of the families of adolescent SA consumers reported having no involvement in either the planning or delivery of services. 63% and 81% of families of adult MH and adult SA consumers respectively have no involvement in either planning or delivery of services.



The greater involvement of parents of children and adolescents may reflect the state's efforts to institute a system of care that strongly encourages family ownership of service planning and delivery. In contrast, adult consumers are often reluctant to involve family members in their treatment. For this reason, the service system has historically placed less emphasis on encouraging family involvement for adult consumers. In taking a person-centered approach to services, providers have to strike a balance between honoring consumers' preferences and encouraging the involvement of an individual's natural support network.

The Division, LMEs and providers must continue to incorporate person-centered thinking into all aspects of the service system. This is a major shift in philosophy that will require time, diligence and collaboration to achieve fully. **The Division expects to see continued gradual improvements in this area.**

Domain 3: Promotion of Best Practices

This domain refers to adopting and supporting those models of service that give individuals the best chance to live full lives in their chosen communities. It includes support of community-based programs and practice models that scientific research has shown to improve the attitudes, behaviors and/or functioning of persons with disabilities, as well as promising practices that are recognized nationally. SAMHSA requires states to report on the availability of evidence-based practices as part of the National Outcome Measures.

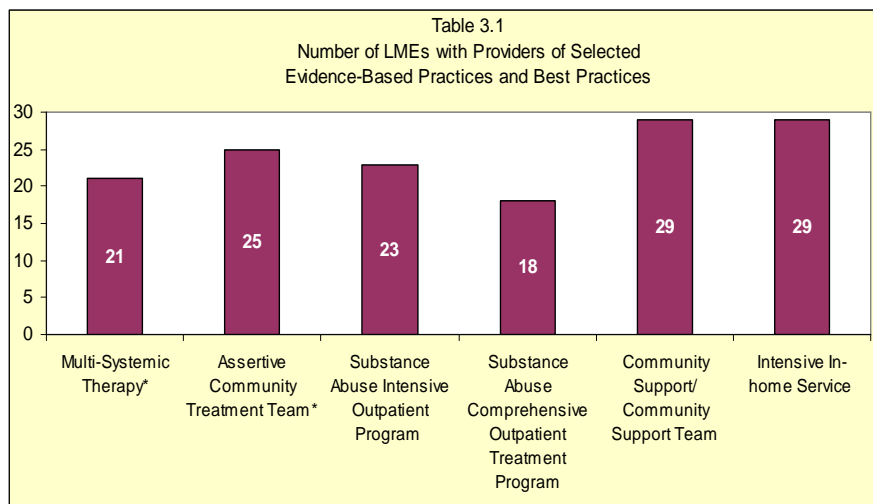
Supporting best practices requires adopting policies that encourage the use of natural supports, community resources and community-based service systems; funding the development of evidence-based practices; reimbursing providers who adopt those practices and providing oversight and technical assistance to ensure the quality of those services. The Division is committed to creating an effective service system based on best practices, as described in the *2005 State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services*, and as indicated by the adoption of new service definitions that reimburse providers for using best practice models of care. The Division is currently providing grant funds to four LMEs (Durham, CenterPoint, Wake and Catawba) to develop the infrastructure within each LME that will promote and sustain the local use of best practices. As pilot

programs, these LMEs are identifying the activities other LMEs will need to undertake to build a highly effective service system across the state.

Measure 3.1: Availability of Evidence-Based Practices

As noted in Measure 2.1 (Consumer Choice of Providers), the LMEs have endorsed over 2000 agencies to provide the type of services through which many evidence-based practice models can be reimbursed.

Table 3.1 shows the number of LMEs that have enrolled agencies to provide six best practice services. Two of these – multi-systemic therapy and assertive community treatment team (marked with an asterisk) – are evidence-based practices. The remaining four are service definitions that encourage the use of best practice models. All of the LMEs have enrolled providers to provide community support and intensive in-home services. In addition, over three-fourths have intensive outpatient services for SA consumers and assertive community treatment teams for adult MH and SA consumers. More than three-fifths have providers enrolled to provide comprehensive outpatient treatment for SA consumers and multi-systemic therapy for child MH and SA consumers. The Division will continue to work with LMEs to increase the availability of best practice models in all areas of the state. The Division is currently working on strategies to ensure that providers deliver these services in accordance with quality standards.



For consumers with developmental disabilities, the state currently has about 596 providers to provide services for up to 10,000 individuals through the Community Alternatives Program for Mental Retardation and Developmental Disabilities (CAP-MR/DD), a Home & Community Based Waiver granted by CMS. Waiver services are designed to be flexible enough to fit an individual's changing needs, and as such, represent a best-practice approach to supporting individuals with developmental disabilities.

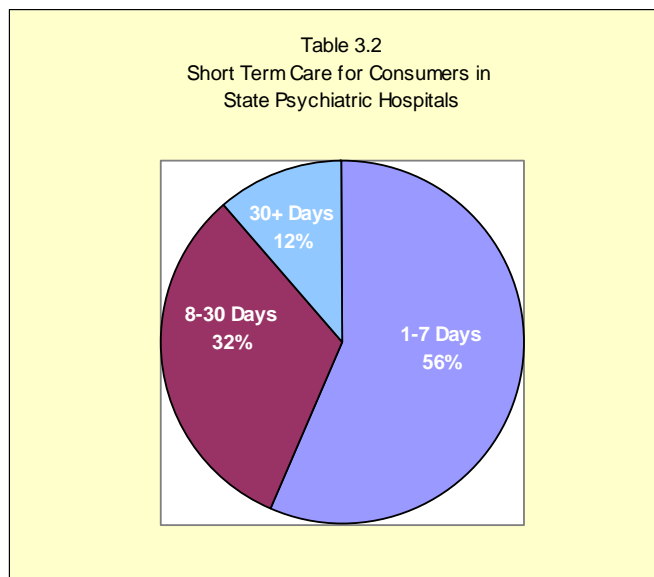
Measure 3.2: Management of State Hospital Usage

North Carolina is committed to developing a service system in which individuals receive the services and supports they need in their home communities whenever possible. This is a particularly critical component of care in times of crisis. Service systems that concentrate on preventing crises and providing community-based crisis response services can help individuals to maintain contact with and receive support from family and friends, while reducing the use of state-operated psychiatric hospitals.

As reported in October 2006 North Carolina has historically used its state psychiatric hospitals to provide more short-term care (30 days or less) than other states. The majority of states do not have short-term care

units in their state hospitals. Instead acute care is provided in private hospitals, reserving the use of state psychiatric hospitals for consumers needing long-term care. As a result North Carolina has served more people overall in its state hospitals and average lengths of stay have been shorter than the national average.

Table 3.2 shows that 88% (15,233) of discharges during the first two quarters of SFY 2006-07 (July-December 2006) were for consumers with lengths of stay for 30 days or less. Of those 8,714 (56% of total discharges) were for consumers who discharged within 7 days of admission.



The use of state hospitals for short-term care reflects the lack of community-based crisis services, psychiatric units in private hospitals, and services to help individuals with complex, chronic disabilities maintain stability while living in their home communities. In particular, services such as partial hospitalization, acute treatment units and crisis stabilization services must be developed, as well as more assertive community treatment teams, intensive outpatient substance abuse treatment, and specialized services for individuals who have both mental retardation and mental illness.

Moving the state toward providing short-term care close to a consumer's home and focusing state psychiatric hospital care on consumers with long-term needs is a major goal of system reform efforts. The LMEs are currently submitting plans to the Division for developing comprehensive local crisis service systems. In addition to these efforts, success in this area will depend on developing effective individualized crisis plans within each consumer's PCP. **As these initiatives move forward, the Division expects to see a positive, but gradual, improvement on this issue.**

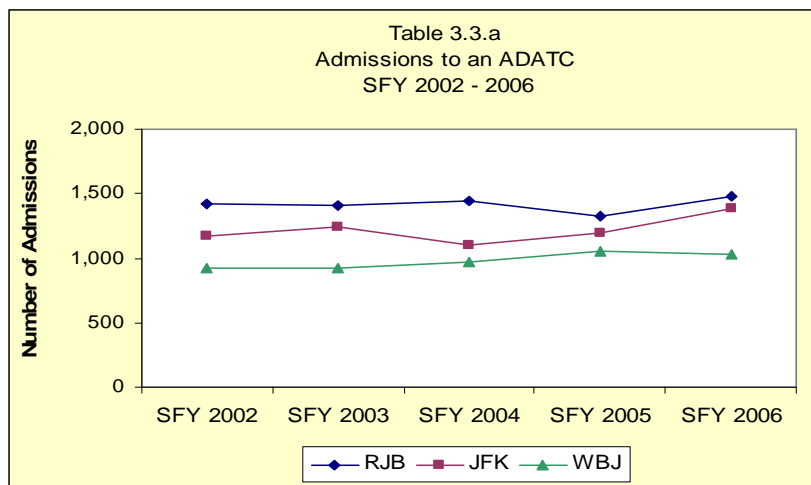
Measure 3.3: Management of State Alcohol and Drug Treatment Center (ADATC) Usage

While the Division is working to reduce short-term use of the state psychiatric hospitals, it is working to increase the use of the state's ADATCs for acute care. As Table 3.3.a shows, total admissions across all ADATCs has increased 10% from 3516 to 3891 in the past five years.

- Admissions at the Robert J. Blackley (RBJ) facility increased by 56 (from 1,421 to 1,477)
- Admissions at the Julian F. Keith (JFK) facility increased by 215 (from 1,175 to 1,390)

- Admissions at the Walter B. Jones (WBJ) facility increased by 104 (from 920 to 1,024)

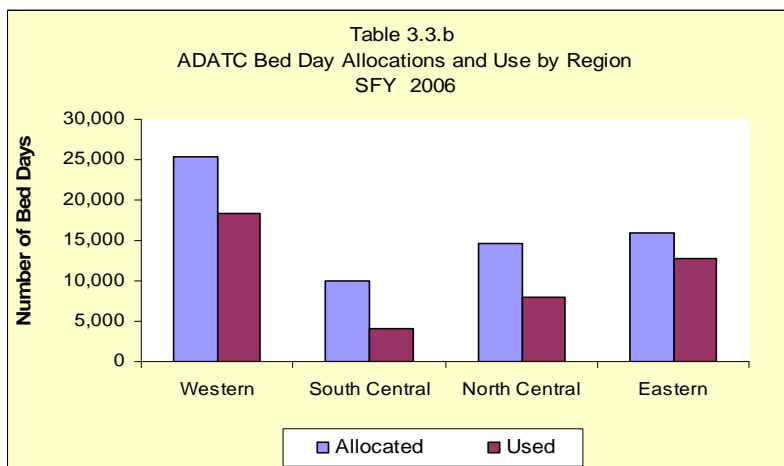
RJB total admissions increased by 16% and JFK admissions increased 12% in the past year. Both JFK and RJB have acute beds and admit individuals with substance abuse issues who have been involuntarily committed. WBJ does not presently admit individuals on involuntary commitment. WBJ showed a slight decrease of 3% in their sub-acute admissions in the past year. However, twenty-four acute beds are scheduled to open at WBJ in April 2007. This will enable WBJ to serve individuals with substance abuse treatment needs who are presently admitted to Cherry Hospital.



ADATC Facilities: JFK = Julian F. Keith, RJB = Robert J. Blackley, WBJ = Walter B. Jones

As can be seen in Table 3.3.b, ADATC bed day utilization shows a decline from 2004 to 2006 leaving ADATCs with unused capacity. This unused capacity reflects two major factors – decreased lengths of stay for persons receiving acute care and a need to identify methods to increase access for individuals needing longer-term (sub-acute level, ASAM III.7) care.

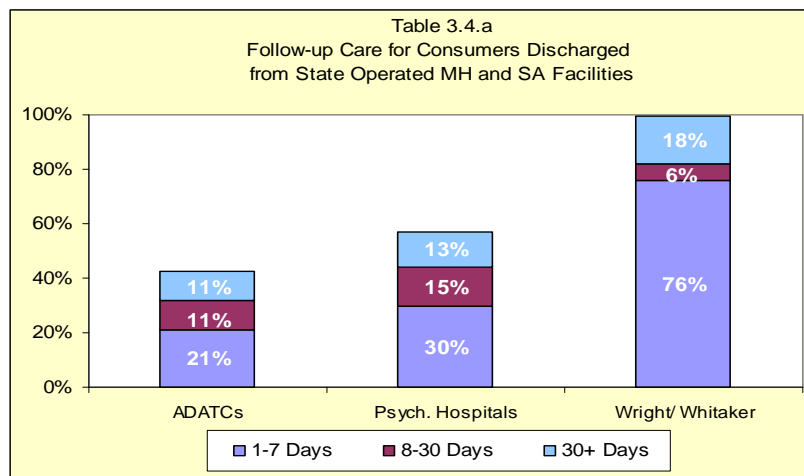
As more acute care units are opened in the ADATCs and efforts are made to increase identification of and access for persons needing longer-term SA services, the Division expects the usage of the ADATCs to increase.



Measure 3.4: Continuity of Care Following Discharge from State Facilities

Continuity of care for consumers after discharge from a state facility is critically important in preventing future crises and supporting an individual's successful transition to community living. A follow-up service within 7 days of discharge from a state facility is the current NC requirement in the DHHS-LME Performance Contract, based on Health Plan Employer Data and Information Set (HEDIS®) measures.¹¹ Developmental centers adhere to a stricter best practice standard, which ensures that individuals moving to community settings receive pre-discharge planning and immediate care upon discharge.

As shown in Table 3.4.a, about two-fifths of persons (43% out of 841) discharged from state alcohol and drug treatment centers (ADATCs) are seen for follow-up care, with 21% receiving care within 7 days of discharge. Almost three-fifths of persons (58% out of 4,133) discharged from state psychiatric hospitals receive follow-up care, with 30% being seen within 7 days. All children and adolescents discharged from the state residential facilities (Whitaker and Wright Schools) receive follow-up care, with over three-fourths (76% out of 17) being seen within a week of leaving the facility.



For individuals moving from the developmental centers to the community, transition planning begins many months prior to discharge.¹² This involves multiple person-centered planning meetings between the individual, their guardian, the treatment team and the provider that has been selected by the individual and their guardian. Service delivery begins immediately upon leaving the developmental center. Between January 1, 2006 and December 31, 2006, a total of 18 individuals were discharged from the general population of the developmental centers to the community.¹³ All eighteen individuals went directly from services at the developmental centers to services in the community. Table 3.4.b shows the type of community setting to which the individuals moved.

¹¹ Best practice is for individuals with MH or SA disorders to receive care within 3 days. As the community service system stabilizes, the Division will increase expectations for timely follow-up community care.

¹² Best practice for persons with DD moving from one level of care to another is to receive immediate follow-up care that adheres to prior planning decisions that involved all relevant parties.

¹³ This number does not include persons discharged from specialty programs or respite care in the developmental centers.

Table 3.4.b
Follow-Up Care for DD Consumers Discharged from State Developmental Centers
Calendar Year 2006

Time Period	Number of Individuals Moved to Community	Type of Community Setting
January – March 2006	3	2 to ICF-MR group home 1 to supervised living home
April – June 2006	6	1 to ICF-MR group home 3 to supervised living home 1 to alternative family living home 1 to natural family
July – September 2006	7	3 to ICF-MR group home 3 to supervised living home 1 to alternative family living home
October – December 2006	2	2 to ICF-MR group home

As progress is made on the state’s strategic objective to stabilize the provider system, the Division expects to see gradual improvement in timely follow-up care for persons discharged from the psychiatric hospitals and ADATCs and continued immediate care for persons moving to the community from the developmental centers.

Domain 4: Consumer-Friendly Outcomes

Consumer Outcomes refers to the impact of services on the lives of individuals who receive care. One of the primary goals of system reform is building a recovery-oriented service system. Recovery for persons with disabilities means having independence, stability and control over one’s own life, being considered a valuable member of one’s community and being able to accomplish personal and social goals.

All people – including those with disabilities – want to be safe, to engage in meaningful daily activities, to enjoy time with supportive friends and family and to participate positively in the larger community. The SAMHSA National Outcome Measures and the CMS Quality Framework include measures of consumers’ perceptions of service outcomes and measures of functioning in a variety of areas, including:

- Symptom reduction, abstinence, and/or behavioral improvements.
- Housing stability and independence.

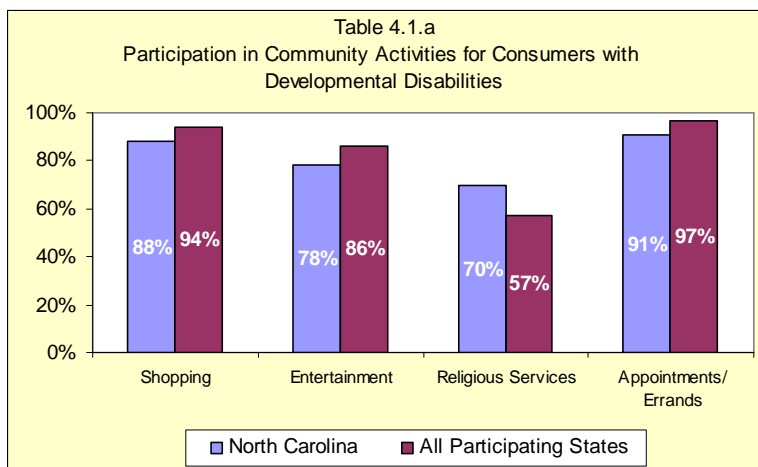
- Employment and education.
- Social connectedness.
- Reduction in criminal involvement.

The Division is currently working to ensure that individual progress on these consumer outcomes is addressed as a regular part of developing person-centered plans for every consumer. Based on analysis of current information, the Division has identified improvements in housing and employment opportunities as strategic objectives for the next three years. Division and local agencies will continue analyzing consumer outcomes data to monitor progress in these areas and to identify other areas that require policy development or targeting of funds for training and technical assistance in clinical practice and for other service system enhancements.

Measure 4.1: Outcomes for Persons with Developmental Disabilities

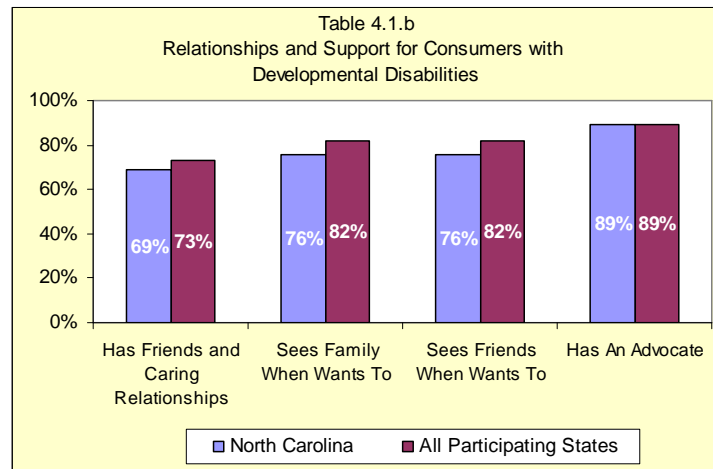
The October 2006 report provided the most recent data available on the issues of housing and employment for persons with developmental disabilities. These measures will be updated in October 2007 when new data become available. Community inclusion and meaningful activities are also national goals emphasized by CMS for persons with DD.

In annual interviews with DD consumers in 2006, most individuals in North Carolina reported participating in community life (Table 4.1.a). North Carolina lagged slightly behind the average among all states using the survey in consumer participation in shopping, entertainment and errands; however, more DD consumers in North Carolina attended religious services than in other states. (See Appendix C for details on this survey.)



- 88% of NC consumers went shopping compared to 94% in all participating states.
- 78% of NC consumers went out for entertainment activities compared to 86% in all participating states.
- 70% of NC consumers attended religious services compared to 57% in all participating states.
- 91% of NC consumers ran errands and kept appointments compared to 97% in all participating states.

Table 4.1.b shows that approximately three-fourths of North Carolina’s DD consumers have access to supportive family, friends and advocates. However, consumers in our state lag slightly behind other states in this area. Although fewer North Carolinians report having friends or being able to see them or family members when they want to compared to the average among all participating states, the percent who report having an advocate is the same as those in all participating states.



- 69% of consumers report having friends and caring relationships, compared to 73% in all participating states.
- 76% of consumers report seeing their family and friends when they want to, compared to 82% in all participating states.
- 89% of consumers in both North Carolina and all participating states report having an advocate.

The lower percentages for NC consumers who report having caring relationships (Table 4.1.b) and participating in community activities (Table 4.1.a) indicate the need for increased opportunities for consumers to become involved in community life in more meaningful and regular ways. The Division will continue to work with LMEs, providers, and consumers to develop strategies to increase opportunities for meaningful participation in activities readily available to local citizens. **As more community services for persons with DD are generated, the Division expects to see gradual improvement in this area.**

The Division is currently developing outcome measures for consumers with developmental disabilities that will be included in the outcomes system currently used with all mental health and substance abuse consumers. This will allow more comprehensive tracking of life outcome changes for the developmental disability population on an ongoing basis and incorporation of that information into the person-centered planning process.

Measure 4.2: Outcomes for Persons with Mental Health Disorders

For persons with mental illness, housing and employment are key to regaining personal control of one’s life. Successful engagement in services for even three months can begin to build the stability and control that improve consumers’ lives and give them hope for further recovery.

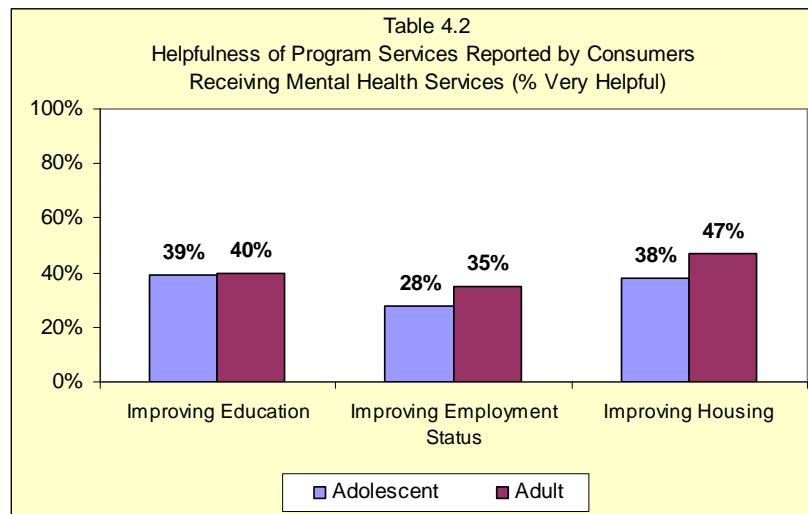


Table 4.2 shows how mental health consumers in SFY20 05-06 perceived the impact of the first three months of treatment on their lives. While three months is insufficient time to judge the long-term effect of treatment, building hope at the outset is an important factor in engaging individuals in their treatment and sustaining improvements over time (See Appendix C for details on the NC-TOPPS system used to collect this data.)

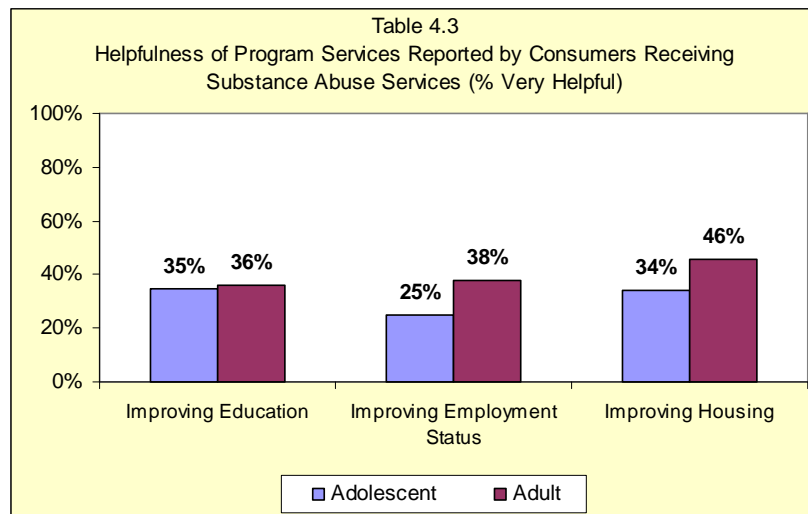
- Approximately two-fifths of adolescent and adult MH consumers reported that services helped improve their education.
- Predictably, more adults (35%) than adolescents (28%) reported improvements in their employment status.
- Adults (47%) also reported improvements in housing more frequently than adolescents (38%).

Stable housing, employment and educational outcomes are difficult to achieve when confronting a mental illness. For those who have struggled over time, believing that services can help is also difficult. **As the Division, LMEs and providers target improving housing and employment opportunities over the next three years, the Division expects to see a gradual improvement in this area.**

Measure 4.3: Outcomes for Persons with Substance Abuse Disorders

Individuals with substance abuse disorders, like those with mental illness, need stable housing and employment to regain personal control of their lives. Successful engagement in the first three months of service is especially critical for this population of consumers, because of the chronic, debilitating nature of addictions.

Table 4.3 on the next page, shows how substance abuse consumers in SFY 2005-06 perceived the impact of the first three months of treatment on their lives. Again, perceptions after three months of service is primarily an indicator of the individual's hope for recovery and engagement in services, both of which are key for achieving and sustaining improvements over time. (See Appendix C for details on the NC-TOPPS system used to collect this data.)



Overall, SA consumers perceptions of care are much like those of MH consumers.

- Slightly over one-third of adolescent (35%) and adult (36%) SA consumers reported that services helped improve their education.
- Predictably, more adults (38%) than adolescents (25%) reported improvements in their employment status.
- Adults (46%) also reported improvements more frequently than adolescents (34%).

Stable housing, employment and educational outcomes are difficult to achieve when confronting a substance abuse disorder. For those who have struggled with an addiction over time or who confront co-occurring disorders, believing that services can help is especially difficult. **The Division will continue to track these measures and expects that adults and adolescents who remain engaged in services for more than the three months reported here will continue building hope and sustaining improvements in these areas.**

Domain 5: Quality Management Systems

Quality Management refers to a way of thinking and a system of activities that promote the identification and adoption of effective services and management practices. The Division has embraced the CMS Quality Framework for Home and Community-Based Services, which includes four processes that support development of a high-quality service system:

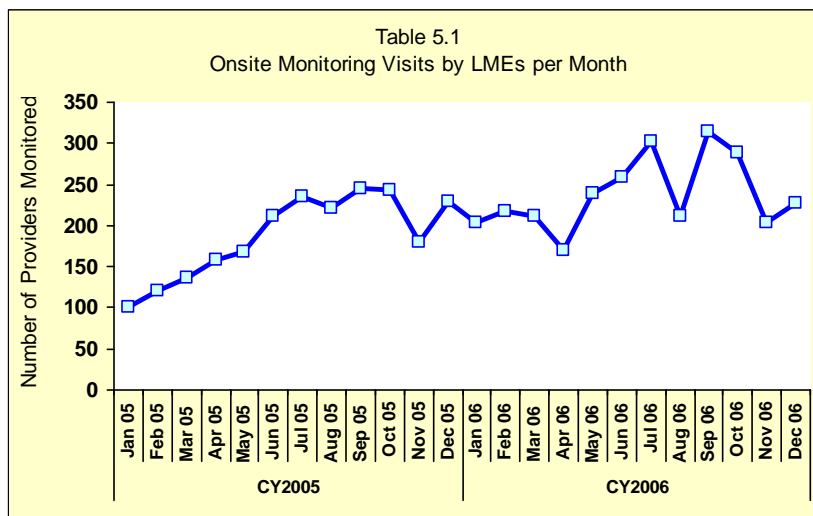
- **Design**, or building into the system the resources and mechanisms to support quality.
- **Discovery**, or adopting technological and other systems to gather information on system performance and effectiveness.
- **Remediation**, or developing procedures to ensure prompt correction of problems and prevention of their recurrence.
- **Improvement**, or analyzing trends over time and patterns across groups to identify practices that can be changed to become more effective or successful.

These processes include activities to ensure a foundation of basic quality and to implement ongoing improvements. The first set of activities, often labeled **quality assurance**, focuses on compliance with rules, regulations and performance standards that protect the health, safety and rights of the individuals served by the public mental health, developmental disabilities and substance abuse services system. The second set of activities, labeled **quality improvement**, focuses on analyzing performance information and putting processes in place to make incremental refinements to the system.

Measure 5.1: Assurance of Basic Service Quality

A major goal of system reform has been the separation of service delivery from service oversight. The LMEs are responsible for monitoring the quality of services provided by private agencies and assisting those agencies to resolve problems quickly and effectively. The Division set a performance requirement in the DHHS-LME Performance Contract to promote regular monitoring and resolution of problems in provider agencies.

As Table 5.1 shows, oversight of provider agencies has been somewhat inconsistent in the past six months compared with the overall pattern of the steady improvements. The number of monitoring visits has increased over the past two calendar years from an average of 188 per month in 2005 to 238 per month in 2006. During the same time period, the percent of visits that found issues needing correction dropped from 74% to 72% and the percent of those issues that were addressed satisfactorily in a timely way improved from 91% to 97%.



The Division is currently revising the rules and reporting requirements that guide LMEs' oversight of providers to standardize monitoring decisions and coordinate monitoring activities among DHHS agencies. **The Division expects some continued variation in this area as LMEs align their practices to the new expectations and their provider communities develop. As the provider community matures and providers achieve national accreditation, the Division expects the number of monitoring visits to level off.**

Measure 5.2: Quality Improvement Activities

The DHHS-LME Performance Contract also requires LMEs to conduct improvement projects to build service capacity and quality. As reported in October 2006, LMEs reported an average of five projects each for SFY 2005-06. Among the LMEs, approximately one-third reported involving their Consumer

and Family Advisory Committees (CFACs) in those projects. The roles of those CFACS varied, as shown in Table 5.2.

Table 5.2 CFAC Involvement in LME Quality Improvement Projects	
Primary Type of Involvement	Number of CFACs
Provided input on project topic	1
Provided rationale or basis for project	2
Participated on project team	3
Participated in analysis of data and decisions about strategies for improvement	2
CFAC subcommittee had responsibility for project	3
TOTAL	11

CFACs provide valuable contributions to quality management activities by identifying areas for improvement that are meaningful to consumers and their families and assisting in the activities and evaluation of improvement projects.

The Division continues to encourage LME improvement efforts by making data on consumer incidents and outcomes available for use in identifying patterns and trends in service quality. In addition, the Division began publishing the quarterly *Community Systems Progress Indicators Report* in November 2006. This report compares individual LMEs' progress to statewide averages in three domains: Service Delivery, Service Quality, and Service Management.

At the state level, the Division is currently working with consultants to develop a three-year strategic plan, which will have identified objectives and measures for tracking progress on those objectives. The identified objectives include:

- Developing and stabilizing a highly qualified provider system.
- Implementing comprehensive crisis services.
- Assuring a unified system and standardization across the state.
- Increasing opportunities for consumer employment.
- Increasing opportunities for consumer housing.

With the implementation of the strategic plan and the continuing work of LMEs and their CFACs, the Division expects the quality and effectiveness of improvement efforts to improve over time at both the state and local levels.

Domain 6: System Efficiency and Effectiveness

System Efficiency and Effectiveness refers to the capacity of the service system to use limited funds wisely -- to serve the persons most in need in a way that ensures their safety and dignity while helping them to achieve recovery and independence. An effective service system is built on an efficient management system, key features of which include good planning, sound fiscal management and diligent information management.

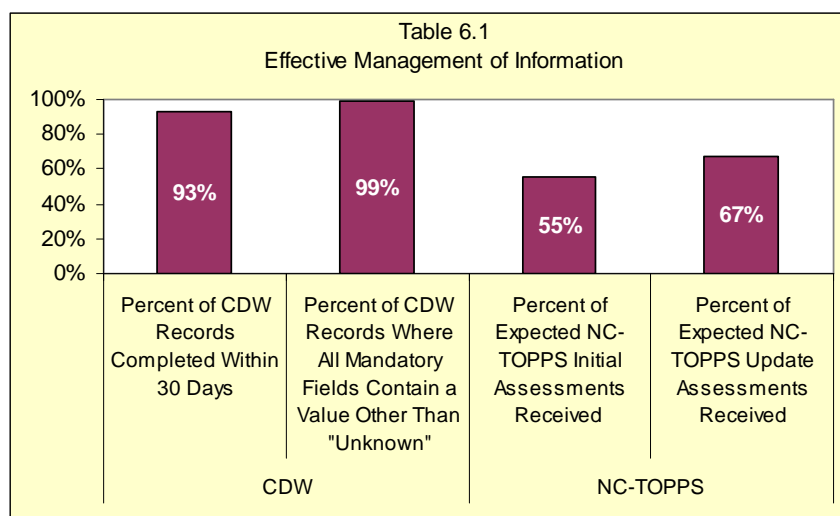
The DHHS-LME Performance Contract serves as the Division's vehicle for evaluating LME efficiency and effectiveness. The scope of work of the contract is each LME's Local Business Plan, which lays out the requirements and local plan for fulfilling each function. In addition, the contract contains thirty statewide performance measures that the Division tracks and reports on its website quarterly. The DHHS-LME Performance Contract is currently being revised and renewed for the three-year period beginning in SFY 2007-08. As part of that process, the LMEs are submitting new Local Business Plans that will reflect their strategies for improving areas of weakness and achieving the Division's strategic objectives discussed above. Statewide compliance measures will be revised for SFY 2007-08 to reflect these changes and results will be incorporated into future reports.

Measure 6.1: Business and Information Management

Making good decisions requires the ability to get accurate, useful information quickly, easily and regularly. It also requires efficient management of scarce resources. Staff at all levels need to know the status of their programs and resources in time to take advantage of opportunities, avoid potential problems, make needed refinements and plan ahead.

The current DHHS-LME Performance Contract includes a number of requirements for timely and accurate submission of financial and consumer information. The LMEs are responsible for ensuring regular submission of data on consumers served through the Client Data Warehouse (CDW) and consumer outcomes data through the NC Treatment Outcomes and Program Performance System (NC-TOPPS). Compliance with these requirements gives a good indication of the efficiency of the LMEs' management capabilities.

The Division has worked diligently in the past few years to ensure compliance with requirements for submitting consumer demographic and disability data to the Client Data Warehouse (CDW), the Division's primary data system. As seen in Table 6.1, on the next page, that effort has resulted in the LMEs exceeding the state standard of submitting 90% of consumer records within 30 days of admission on a regular basis.



The Division is currently working to achieve similar compliance rates on requirements begun in July 2005 for consumer outcomes data in NC-TOPPS. In the eighteen months of this initiative, LMEs have worked hard to improve providers' submission of initial NC-TOPPS data, despite having limited access to information about consumers served by agencies who are directly enrolled to provide Medicaid services. Submission of updated NC-TOPPS information, which is based on information that is readily available to LMEs, grew from 56% in SFY 04-05 to 67% in SFY 05-06. Because of LME and provider efforts, the Division has accumulated data on service outcomes for almost 9,900 MH consumers and 3,000 SA consumers. The Division and LMEs are currently using these data to track and improve service quality for both individuals and the system as a whole.

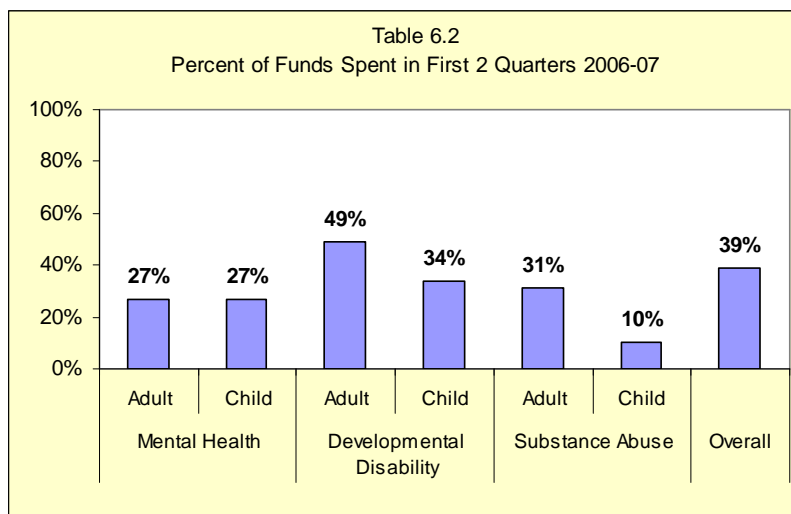
The Division's feedback reports to LMEs have helped them work with providers to improve submission rates steadily. **The Division expects compliance to continue increasing as a result of current efforts.**

Measure 6.2: Efficient Management of Service Funds

Providing effective services requires careful management of limited fund allocations over the course of the fiscal year to ensure that funds are continuously available to serve those most in need. Overspending of funds early in the year leaves no reserves for those who enter the system or continue to need services later in the year. Underspending of funds means that some who could have been served were not.

Table 6.2 on the next page, shows the average LME expenditures of state funds in the first and second quarters of SFY 2006-07 by age-disability group. Assuming that an even spread of dollars across the fiscal year is desirable, approximately 40-60% of funds should have been spent in these two quarters.

While expenditures across all age-disability groups averaged 39% during the first half of this fiscal year, only the LMEs' allocations for adult DD services fall in the expected range for this point in the fiscal year. Spending for all other age-disability groups lag behind. Only 10% of the allocations for child SA services have been expended so far this fiscal year.



The lack of services to SA consumers is, in part, due to many individuals' reluctance to seek help from the public system. The Division, LMEs and providers must make greater efforts to identify, recruit and engage these consumers. In addition, the state has a great need for additional qualified SA providers. The Division's strategic objective on developing a stable, qualified provider community will focus on filling this gap. **The Division expects regular reporting of expenditure disparities among age-disability groups and efforts to recruit additional SA providers to create gradual improvement in this area.**

Measure 6.3: Review of Persons Served in Cost-Bands

The Division is developing a measure to profile expenditure of public funds by age/disability groups in order to analyze the efficient and effective use of funds. This is a SAMHSA National Outcome Measure that will provide regular tracking of high-cost and low-cost service usage. Analysis of consumer groups who are receiving either excessive or insufficient amounts of service across the state will allow the Division to identify areas for improvement in service management, so that policies, technical assistance, and resources can be directed appropriately and effectively. The Division is currently designing the model for this analysis and will report the data in upcoming reports.

Domain 7: Prevention and Early Intervention

Prevention and Early Intervention refers to activities designed to minimize the occurrence of mental illness, developmental disabilities, and substance abuse whenever possible and to minimize the severity, duration, and negative impact on persons' lives when a disability cannot be prevented. **Prevention** activities include efforts to educate the general public, specific groups known to be at risk, and individuals who are experiencing early signs of an emerging condition. Prevention education focuses on the nature of mh/dd/sa problems and how to prevent, recognize and address them appropriately. **Early intervention** activities are used to halt the progression or significantly reduce the severity and duration of an emerging condition.

Preventing or intervening early in a potential problem is much more efficacious – both clinically and financially – than treating a disability that has already caused major impairments and negative consequences in an individual's and family's life. The SAMHSA National Outcome Measures emphasize the use of evidence-based programs to educate and intervene with individuals who may be experiencing early problems associated with substance use. In addition, increasing national attention is being given to preventing or minimizing the impact of mental illness and developmental disabilities.

Measure 7.1: Alcohol and Drug Education Traffic Schools (ADETS)

The North Carolina Alcohol and Drug Education Training School (ADETS) Program is an educational program that is designed for early intervention with individuals who have experienced a first Driving While Impaired (DWI) offense, but who do not have a diagnosable alcohol or substance abuse disorder.

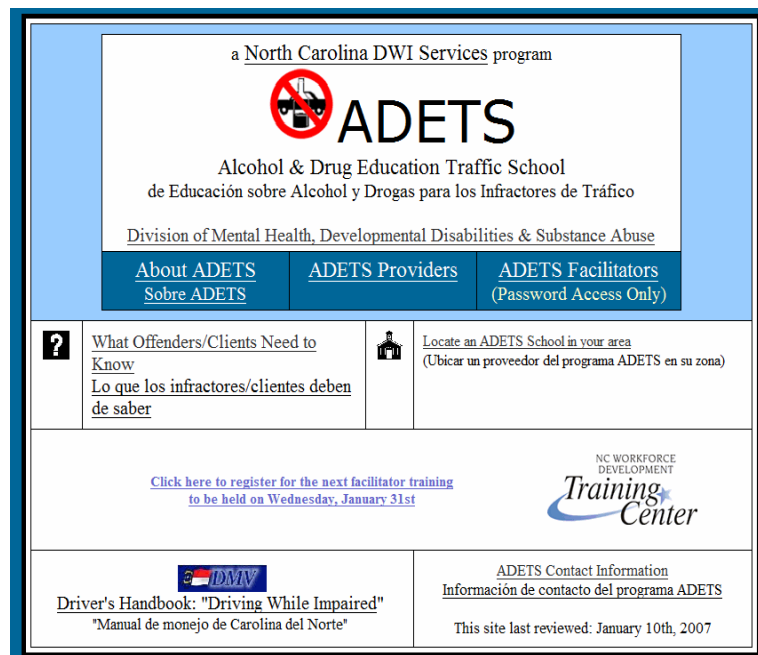
ADETS students have suffered a serious legal consequence due to their substance usage, making them prime candidates for an early intervention program. This program helps them learn about the harmful impacts of alcohol and other drugs and assimilate this information into their personal lives. The program helps students develop a personal plan that will help them have a successful life free of alcohol and other drug abuse.

ADETS was developed in 1980, as part of the Division's comprehensive response to reduce the prevalence of DWI.

- In SFY 05-06, DWI services were completed for individuals with 26,552 DWI convictions.
- Of this total, 5005 persons (19%) completed the ADETS program.

In the last two years, monitoring of the ADETS program has been significantly increased. The Division reviews each of the 154 provider agencies every two years to ensure appropriate implementation and operation of the program at the local level. Monitoring capabilities, at the individual and program level, have been increased substantially as a result of the use of web-based applications described below.

The Division tracks completion of all DWI Services, including ADETS, through the DWI Certificate of Completion (DMH 508-R) system. As of October 2006, the paper tracking system was moved to a web-based application in which assessment, education, and treatment activities are reported to the Division in a real time fashion.



This electronic system has:

- Decreased the Division's processing time from 2 weeks to 24 hours when offenders have completed DWI services and are ready to have their driving privileges reinstated by the Division of Motor Vehicles.

- Reduced providers' paperwork burden and the related copying, mailing and staffing costs.
- Reduced information errors through increased readability and built-in data checks.
- Provided for a system of automatic collection, storage, and retrieval of data.
- Improved data collection and use for decision-making.
- Enabled early identification of potential problems and opportunities for improvement.
- Created a dynamic database for research and program evaluation efforts to measure program efficiency and effectiveness.

In response to changes in GS 122C-142.1 Section 1, ADETS programs increased instruction to a minimum of 16 hours with a class size of no more than 20 participants in October 1, 2006. This legislation also increased qualification requirements for ADETS instructors and increased student fees to "support, evaluate and administer ADET schools." The Division is currently using the funds to conduct an evaluation of the ADETS curriculum and its impact on students' future legal charges. The first phase of this evaluation will be reported to the Legislature in December 2007.

The Division expects the new requirements and additional funds for ADETS to improve the monitoring and delivery of services to first-time offenders.

Measure 7.2: State Synar Program to Reduce Tobacco Sales to Minors

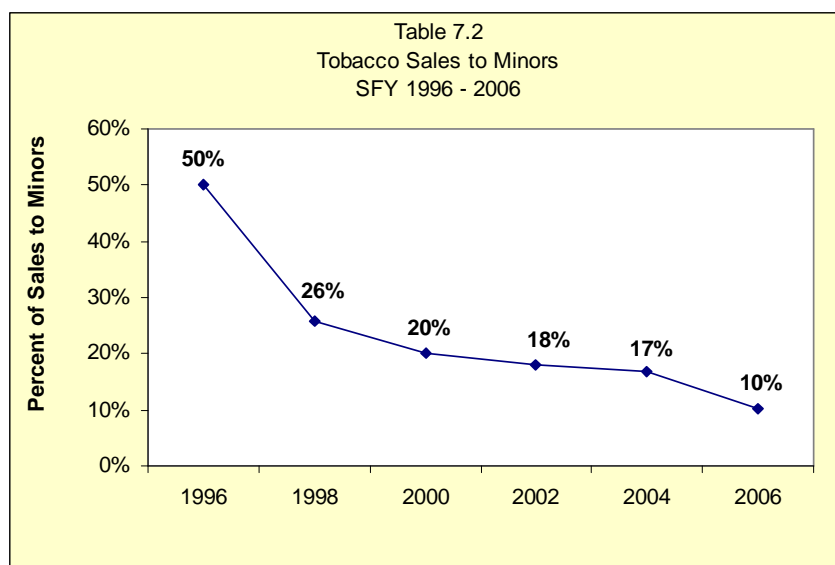
Reducing youth access to tobacco products is one component of the state's comprehensive program to prevent and reduce tobacco use among young people. The Federal Synar Amendment, Section 1926 of the Public Health Service Act, requires all states to conduct specific activities to reduce youth access to tobacco products.

As part of the DHHS-LME Performance Contract, each LME is required to work with its providers to implement Synar activities and report them to the Division twice a year. LME activities include:

- Designation of a liaison to provide community leadership in reducing youth access to tobacco products;
- Provision of at least 8 hours per month of consultation, education and primary prevention regarding youth access through community collaboration, merchant education, law enforcement, and media/public relations activities; and
- Documentation and reporting of activities through a standardized reporting format.

During SFY 2005-06, the LMEs and their contract agencies contributed over 5,800 hours of Synar related activities in their catchment areas.

As part of Synar activities, the state conducts annual random, unannounced inspections of tobacco retail outlets to determine merchant compliance with the state's Youth Access Law, which prohibits the sale of tobacco products to anyone under age 18. As Table 7.2 shows on the next page, the state has made great progress in reducing youth access to tobacco products. Illegal tobacco sales in North Carolina have fallen from 50% to 10% in the last ten years.



Much of the success is due to the Division's long partnership with the NC Department of Crime Control and Public Safety's Division of Alcohol Law Enforcement to provide retailer education and training, to actively enforce the State's Youth Access Law and to raise awareness of this issue in communities across the state. In addition, strong local partnerships between LMEs, substance abuse and public health agencies, law enforcement agencies, retailers, coalitions, youth groups, voluntary agencies and parent organizations have also contributed to the state's success. This Synar Program has been greatly enhanced since 2002 due to funding and support from the NC Health and Wellness Trust Fund Commission's Teen Tobacco Use Prevention and Cessation Initiative.

The Division is currently collaborating with Alcohol Law Enforcement and the Health and Wellness Trust Fund in the "Red Flag" campaign, which promotes the use of color-coded NC driver's licenses to assist retailers in preventing tobacco sales to minors. A red border around the licensee's photo indicates that the card holder may be less than 18 years old and underage for tobacco purchases. The UNC Tobacco Prevention and Evaluation Program is currently evaluating the Red Flag campaign. Additional information on this program is available through the "underage smoking" link at www.ncalc.org.

Conclusion

This report represents the second comprehensive assessment of the performance of the public mental health, developmental disabilities and substance abuse service system since the initiation of system transformation efforts. The Division will continue to strengthen the measurement strategies and mechanisms needed to track the progress and performance of the system. The Division is working to find timely and user-friendly ways to communicate changes that are occurring, in addition to producing this report each fall and spring.

- The Division's "Quality Quick Facts" series initiated in July 2006 on the homepage of the Division's website (<http://www.ncdhhs.gov/mhddsas/>) continues to draw positive responses from stakeholders.
- In November 2006 the Division began publishing a quarterly *Community Systems Progress Indicators Report* to track LMEs' progress on a number of measures included in this report.
- The Division is currently working with consultants to revise the DHHS-LME Contract performance measures and to develop tools for regular on-site review of LMEs' performance of their functions.

All of these efforts will provide additional data for future reports.

The North Carolina mental health, developmental disabilities and substance abuse services system has changed in fundamental and significant ways over the past five years. The Division will continue to work with consumers and families, providers, LMEs and other stakeholders to achieve the goals of the transformation effort.

Appendix A: SAMHSA National Outcome Measures

Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs)

DOMAIN	OUTCOME	MEASURES		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ►	30-day substance use (non-use/reduction in use) ► Perceived risk/harm of use ► Age of first use ► Perception of disapproval/attitude
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ►	Increase in/no change in number of employed or in school at date of last service compared to first service ►	Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ►	Alcohol-related car crashes and injuries; alcohol and drug-related crime
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ►	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ►	NOT APPLICABLE
Social Connectedness	Increased Social Supports/Social Connectedness ¹	Under Development	Under Development	Family communication around drug use
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ►	Unduplicated count of persons served; penetration rate-numbers served compared to those in need ►	Number of persons served by age, gender, race and ethnicity
Retention	Increased Retention in Treatment - Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ► Unduplicated count of persons served ►	Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message
	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ►	NOT APPLICABLE	NOT APPLICABLE
Perception of Care	Client Perception of Care ²	Clients reporting positively about outcomes ►	Under Development	NOT APPLICABLE
Cost Effectiveness	Cost Effectiveness (Average Cost) ²	Number of persons receiving evidence-based services/number of evidence-based practices provided by the State	Number of States providing substance abuse treatment services within approved cost per person bands by the type of treatment	Services provided within cost bands
Use of Evidence-Based Practices	Use of Evidence-Based Practices ²		Under Development	Total number of evidence-based programs and strategies

¹ For ATR, "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.

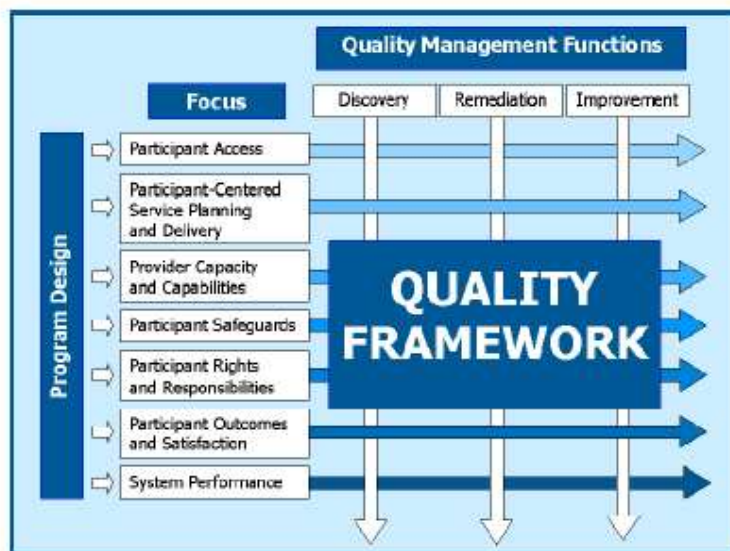
² Required by 2003 OMB PART Review.

Appendix B: CMS Quality Framework

HCBS QUALITY FRAMEWORK

The Home and Community-Based Services (HCBS) Quality Framework provides a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of community services and supports for older persons and individuals with disabilities. The Framework focuses attention on participant-centered desired outcomes along seven dimensions.

Program design sets the stage for achieving these desired outcomes. Program design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring participant health and welfare, and critical safeguards (e.g., incident reporting and management systems).



Quality management encompasses three functions:

- **Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
- **Remediation:** Taking action to remedy specific problems or concerns that arise.
- **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

Focus	Desired Outcome
Participant Access	Individuals have access to home and community-based services and supports in their communities.
Participant-Centered Service Planning and Delivery	Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.
Provider Capacity and Capabilities	There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.
Participant Safeguards	Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
Participant Rights and Responsibilities	Participants receive support to exercise their rights and in accepting personal responsibilities.
Participant Outcomes and Satisfaction	Participants are satisfied with their services and achieve desired outcomes.
System Performance	The system supports participants efficiently and effectively and constantly strives to improve quality.

Quality management gauges the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Program design features and quality management strategies will vary from program to program, depending on the nature of the program's target population, the program's size and the services that it offers, its relationship to other public programs, and additional factors.

The Framework was developed in partnership with the National Associations of State Directors of Developmental Disabilities Services, State Units on Aging, and State Medicaid Directors.



Appendix C: Description of Data Sources

Domain 1: Access To Services

Table 1.1.a Persons in Need (*Prevalence Rates*): The estimates of the percentage of individuals who experience a mental health, developmental, and/or substance abuse disability each year come from the following sources:

- Mental illness – Annual estimates from SAMHSA’s Center for Mental Health Services at: <http://mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/UniformReport.asp>

Adult estimate from URS Table 1: Number of Persons with Serious Mental Illness [sic], age 18 and older, by State, 2005, Midpoint of range between lower and upper limits of estimate. Prepared by NRI/SDICC for CMHS: August 29, 2006.

Child/adolescent estimate from URS Table 1: Number of Children with Serious Emotional Disturbances [sic], age 9 to 17, by State, 2005, Level of functioning score=60, midpoint of range between lower and upper limits of estimates. Prepared by NRI/SDICC for CMHS: August 29, 2006.

Early childhood (ages 0-8) estimates from Glascoe and Shapiro, “Introduction to Developmental and Behavioral Screening.” Reprinted from *Pediatric Development and Behavior Online* <http://www.dbpeds.org> The Division applies the estimates established by CMHS for children ages 9-17 to those ages 0-8, since no consistent estimates have been adopted.
- Developmental Disabilities – Adult and child estimates from Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), <http://rtc.umn.edu/docs/fs0102.html>.
- Substance abuse – Adult and child estimates from *State Estimates of Substance Use from the 2003-2004 National Surveys on Drug Use and Health*, Table B.20, <http://oas.samhsa.gov/nsduh.htm>.

The corresponding numbers of North Carolina residents in need in each age-disability group are calculated using US Census data for the relevant populations as of July 2006.

Table 1.1.b Percent of Persons in Need and Served (*Treated Prevalence*): The percent of persons in need who receive services is calculated by dividing the number of persons who received at least one Medicaid or state-funded service (based on paid claims in the Integrated Payment Reimbursement System (IPRS) and/or Medicaid claims system for the time period October 1, 2005 through September 30, 2006) by the number of persons in need of services. The number of persons in need (the denominator) includes North Carolinians that the state’s MH/DD/SA service system is responsible for serving (ages 3 and over for MH and DD, ages 12 and over for SA). The disability of the consumer is based on the diagnosis reported on the service claim. The public system served 24.5% of the estimated need, including 126,803 adult, 23,038 child and 48,942 adolescent MH consumers; 17,308 adult and 9,575 child/adolescent DD consumers; and 39,975 adult and 3,219 adolescent SA consumers. Persons with multiple disabilities are included in all relevant groups. Persons served in Piedmont LME are not included.

Table 1.2 Persons Seen Within Seven Days of Request: This measure is calculated by dividing the number of persons requesting routine (non-urgent) care into the number who received a service within the next seven days and multiplying the result by 100. The information comes from data submitted by LMEs

and published in the *Quarterly DHHS-LME Performance Contract Reports* for SFY 2005 – SFY 2007. The Division verifies the accuracy of the information through annual on-site sampling of records. More information on the Performance Contract, including the quarterly reports, can be found on the web at: <http://www.ncdhhs.gov/mhddsas/performanceagreement/>.

In January 2006, LMEs began submitting consumer-specific data on individuals who request services to the Division's Client Data Warehouse (CDW). Once reporting has stabilized, future information on timeliness of services will be reported from this system.

Domain 2: Individualized Planning and Supports

Enrolled Providers: The number of provider agencies providing community-based services comes from the Medicaid claims system. As of January 31, 2007, a total of 1,678 community intervention service agencies and 793 providers of Community Alternatives Program for Mental Retardation and Developmental Disabilities (CAP-MR/DD) Waiver services were actively enrolled in the Medicaid claims reimbursement system. An additional 616 child residential facilities in the state are not included.

Tables 2.1.a and 2.2.a Choice Among Persons With Developmental Disabilities: The data presented in these tables are from in-person interviews with NC consumers in the spring of 2006, as part of the National Core Indicators Project (NCIP). This project collects data on the perceptions of individuals with developmental disabilities and their parents and guardians. Approximately 500 in-person interviews with consumers are conducted each year. In addition, over 2,000 mail surveys are sent out each year to parents and guardians of individuals receiving developmental disability services and supports. The interviews and surveys ask questions about service experiences and outcomes of individuals and their families. More information on the NCIP, including reports comparing North Carolina to other participating states on other measures, can be found at: <http://www.hsri.org/nci/index.asp?id=reports>.

Tables 2.1.b and 2.2.b Choice Among Persons With Mental Health And Substance Abuse Disabilities: The data presented in these tables come from clinician-to-consumer update interviews that occurred between July 1, 2006 and December 31, 2006 through the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS). This web-based system collects information on a regular schedule from all persons ages 6 and over who receive mental health and substance abuse services. More information on NC-TOPPS, including annual reports on each age-disability group, can be found at <http://nctopps.ncdmh.net/>. The update interviews included 5,486 adult MH consumers, 2,949 adolescent MH consumers, 1,415 child MH consumers, 2,721 adult SA consumers, and 253 adolescent SA consumers.

Domain 3: Promotion of Best Practices

Table 3.1 Providers of Evidence-Based and Best Practices: Data on endorsed providers comes from the *Service Endorsement Report* published by the DMH/DD/SAS Accountability Team, 12/29/06. Agencies endorsed to provide services in Piedmont LME are not included.

Table 3.2 Short Term Care in State Psychiatric Hospitals: The data come from the Division's Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) HEARTS discharges for the period July 1 - December 31, 2006. The HEARTS data include demographic, diagnostic, length of stay and treatment information on all consumers who are served in State-operated facilities. Lengths of stay are calculated by subtracting the date of admission from the date of discharge. The percents for each length of stay grouping (1-7 days, 8-30 days, and over 30 days) are calculated by dividing the total number of discharges during July 1-December 31, 2006 into the number of discharges in each length of stay grouping and multiplying by 100.

Table 3.3.a Admissions to ADATC Facilities: These data come from the Division's HEARTS data for SFY 01-02 through SFY 05-06.

Table 3.3.b ADATC Bed Day Allocations and Use by Region: The allocation data come from the Division's SFY 05-06 budget allocations to each LME for use of the state ADATC facilities. The bed day usage is calculated as the number of days billed through HEARTS for consumers from each LME during SFY 05-06.

Table 3.4.a Follow-up Care for Consumers Discharged from State Operated MH and SA Facilities: The data come from HEARTS direct discharges during the period April 1 - June 30, 2006 and Medicaid and State Service Claims data for April 1- December 31, 2006. Data from Piedmont LME are not included. Discharges to other state-operated facilities and the criminal justice system are not included. The time between discharge and follow-up care is calculated by subtracting the date of discharge from the date of the first claim for community-based service that occurs after the discharge date. The percents of persons seen within 7 days, 8-30 days and over 30 days are calculated by dividing the total number discharged during the period into the number in each of the groupings of time to follow-up care.

Table 3.4.b Follow-up Care for Consumers Discharged from State Developmental Centers: These data come from reports submitted quarterly by the developmental centers to the Division. The numbers do not include persons discharged from specialty programs (such as programs for persons with both mental retardation and mental illness) or persons who were discharged after receiving respite care only.

Domain 4: Consumer Outcomes

Tables 4.1.a and 4.1.b Service Outcomes For Persons With Developmental Disabilities: This information comes from NCIP, described in Tables 2.1.a and 2.2.a above.

Tables 4.2 and 4.3 Service Outcomes for Individuals With Mental Health And Substance Abuse Disabilities: This information comes from NC-TOPPS, described in Tables 2.1.b and 2.2.b above.

Domain 5: Quality Management

Table 5.1 Assurance of Basic Service Quality: The information comes from data submitted by LMEs and published in the quarterly DHHS-LME Performance Contract reports for CY05 - CY06 by the Division. The Division verifies the accuracy of the information through annual on-site sampling of records.

Table 5.2 Quality Improvement Activities: The information on LMEs' involvement of consumer and family members in improvement activities comes from annual Quality Improvement reports that the LMEs submitted to the Division in July 2006 as part of their DHHS-LME Performance Contract requirements.

Domain 6: Efficiency and Effectiveness

Table 6.1 Effective Management of Information: The data for information management come from calculations of compliance for requirements in the DHHS-LME Performance Contract.

- Consumer Data Warehouse (CDW) admissions data and service claims data are used to calculate the completeness of submitted records. Data on Piedmont LME are not included. The number of expected records is based on consumers whose first Medicaid or state service claim date was during July – September 2006. The percent of records submitted within 30 days is calculated by dividing the number of expected consumer records into the total number of CDW records received during January 1, 2006 through September 30, 2006 and multiplying the result by 100. The information on consumer

records with all mandatory data fields containing a value other than “unknown” is calculated by dividing the number of records having 100% of the five mandatory data fields containing a value other than unknown by the total number of records reported and multiplying the result by 100. Mandatory fields include the consumer’s county, race, ethnicity, gender, and marital status.

- NC Treatment Outcomes & Program Performance System (NC-TOPPS) data submissions for Initial Interviews includes persons whose first date of a state-funded service claim in IPRS was during April 1- June 30, 2006. The percent of Initial NC-TOPPS received is calculated by dividing the expected number of Initial Interviews due during April through June 2006 into the number received from April 1 through December 31, 2006 and multiplying by 100. The percent of Update Interviews received is calculated by dividing the number of 3-Month Update Interviews due during April 1 through June 1, 2006 into the number received from April 1 through December 31, 2006 and multiplying by 100.

Table 6.2 Percent of Funds Spent: These data are calculated by dividing the total annual allocations for State and non-Medicaid Federal Funds as of December 31, 2006 into the total expenditures reported in IPRS for the time period July 1 - December 31, 2006. Expenditures of the Piedmont and Smoky Mountain LMEs are not included.

Domain 7: Prevention and Early Intervention

Measure 7.1 Alcohol and Drug Education Traffic Schools (ADETS): The web-based DWI Certificate of Completion (DMH 508-R) system and the ADETS curriculum are available via the internet at <http://ncadets.org>. This site provides information to the ADETS client, the program provider and the instructor in both English and Spanish. The ADETS site links to a statewide Directory of ADETS Schools, including those with specialized services, such as bilingual instruction, and provides an interactive map to allow individuals to locate and connect easily with appropriate authorized providers.

Table 7.2 Tobacco Sales to Minors: The Synar Program is named for former U.S. Representative Michael Synar. Data on the percent of sales to minors come from the annual Synar Survey which North Carolina conducts, as required by federal law, to ensure that all states are showing progress in reducing access or tobacco sales to minors. The survey has been implemented since 1996.